diamond dental
SLEEP SOLUTIONS

Patient Intake Form

info@diamondsleepsolutions.com | 2983 Long Beach Road, Oceanside, NY 11572
Phone. 516.778.9296 | Fax. 516.299.9117

Introductions:

Name: _____ Preferred Name: _____

Address: _____City/State/Zip:_____

Date of Birth: ____/____/_____ Best Contact Phone: (H C W): _____

Email: _____ *This information will not be shared*

Sleep Physician: _____ Phone: _____

General Physician: _____ Phone: _____

Dentist: _____Phone: _____

Other : _____ Phone:_____

Concerns:

What Prompted You to Seek Diagnosis and Treatment?

_____

Sleep Apnea Snoring Alternative to CPAP

Have you ever had a sleep study performed? Y N How long ago?_____

Any Use of Oral Appliance? Y N Temporary/Trial _____

Jaw Joint Problems? None Pain Limitations: _____

When was your last dental exam/cleaning? _____

Any Dental Treatments Recommended? _____

Other Dental Concerns: _____

Any Other Concerns: _____

Treatment Will Be Successful When: _____

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Health Information

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Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex
☐ Local Anaesthetic ☐ Other (if yes please explain)_____

Have you ever had any of the following? Please check if applies:

Y N		Y N		Y N	
☐☐	AIDS or HIV	☐☐	Genital Herpes	☐☐	Psychiatric Care
☐☐	Anemia	☐☐	Glaucoma	☐☐	Psychiatric Care
☐☐	Arthritis	☐☐	Hay Fever	☐☐	Radiation Treatment
☐☐	Artificial Heart valve	☐☐	Heart Attack/Failure	☐☐	Respiratory Problems
☐☐	Artificial Joints	☐☐	Heart Disease	☐☐	Rheumatic Fever
☐☐	Asthma	☐☐	Heart Murmur MVP	☐☐	Sinus Problems
☐☐	Blood Disease	☐☐	Heart PACE MAKER	☐☐	Stomach Problems
☐☐	Cancer	☐☐	Hepatitis A, B or C	☐☐	Stroke
☐☐	Chemotherapy	☐☐	High Blood Pressure	☐☐	Tuberculosis
☐☐	Diabetes	☐☐	Leukemia	☐☐	Tumors
☐☐	Drug Addiction	☐☐	Liver Disease	☐☐	Ulcers
☐☐	Epilepsy or seizures	☐☐	Kidney Disease	☐☐	Venereal Disease
☐☐	Excessive Bleeding	☐☐	Parathyroid disease	☐☐	OTHER:_____
☐☐	Fainting or Dizziness				

Have you ever had a serious head or neck injury? ( ) YES ( ) NO If yes please explain_____

Have you ever been told you need to pre-medicate with antibiotics prior to dental work? ( ) NO
( ) YES _____

Do you or have you taken Fosamax? ( ) YES ( ) NO _____

Are you on a special diet? ( ) YES ( ) NO _____

Do you use, or have you used, tobacco? ( ) YES ( ) NO _____

Do you use controlled substances? ( ) YES ( ) NO _____

☐ Please List ANY MEDICATIONS you are taking:_____

WOMEN: Are you: ☐ Pregnant? Due date_____ ☐ Taking Oral Contraceptives? ☐ Nursing?

In Case of **EMERGENCY** give **NAME** and **PHONE NUMBER** of someone **NOT LIVING WITH YOU**.

_____

Are you now under the care of a physician or have you ever had a serious illness not listed above?

( ) YES ( ) NO If yes please explain_____

Name of Physician: _____ Phone:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

Signature of Patient (or parent or guardian) _____

Relationship to Patient:_____ Date:_____

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Epworth Sleepness Scale

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The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. Use the following scale to choose the most appropriate number for each situation over the past two weeks. Even if you don't usually do this activity, please give your best estimate:

0 = would never doze or sleep.
1 = slight chance of dozing or sleeping
2 = moderate chance of dozing or sleeping
3 = high chance of dozing or sleeping

Name: _____ Date: _____

HEIGHT: Feet____Inches_____ WEIGHT: Pounds_____ NECK SIZE:_____

Situation	***Chance of Dozing or Sleeping***
Sitting and Reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic	
Total Score	

0-5: It is unlikely that you are abnormally sleepy
6-9: You have an average amount of daytime sleepiness
10-15: You may be excessively sleepy depending on the situation
16-24: You are excessively sleepy

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CPAP Intolerance Form

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Patient name: _____ DOB: _____

☐ **I have attempted to use the nasal CPAP device** to manage my sleep-related breathing disorder and find it intolerable to use on a regular basis for the following reason(s):

- ☐ Mask Leaks
- ☐ Mask and/or device uncomfortable
- ☐ Unable to sleep comfortably
- ☐ Noise from the device disturbs me and/or my bed partner's sleep
- ☐ Restricts movement during sleep
- ☐ Does not seem to be effective
- ☐ Straps/headgear cause discomfort
- ☐ Pressure on upper lip causes tooth-related problems
- ☐ An unconscious need to remove mask at night
- ☐ Latex allergy
- ☐ Claustrophobia
- ☐ Other: (explain history below)

_____

_____

_____

☐ **I have never worn a CPAP** and I refuse to wear one because:

- ☐ Claustrophobia
- ☐ I travel and refuse to carry the CPAP machine and hose
- ☐ I cannot have my movement restricted while sleeping
- ☐ Latex allergy
- ☐ Other:_____

Because of my unwillingness to use the CPAP device, I wish to have an alternative method of treatment. I would like to try an oral appliance in an attempt to control my snoring and obstructive sleep apnea.

Signature of Patient _____ Date:_____

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HIPAA Notice of Privacy Practices Acknowledgment Form

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We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples include setting up appointments for you; examining your teeth, prescribing medications, referring you to another doctor, or getting copies of you health information from another professional, dental insurance, etc.
The full Notice is available in the reception room and business office.

This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

Please sign below indication that you are aware of our HIPAA privacy practices

I am aware of the HIPAA Privacy Policy.

Signature of Patient _____ Date:_____

You may Refuse to sign this acknowledgement. If you refuse to sign please indicate reason:

Reason for Refusal to sign:

_____

_____

Privacy directors signature_____

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Authorization to Release Medical Information

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Date:____/____/_____ Date of Birth: ____/____/_____ SSN: _____

Patient Name: _____

Address: _____City/State/Zip:_____

I, the undersigned, do hereby grant permission for **Dr. Asher Diamond** to

☐ obtain from or ☐ release to:

_____

(Name of person or institution the information will be coming from)

_____

(Address of person or institution the information will be coming from)

The following information from the patient's clinical record:

☐ All necessary medical records

☐ Other: _____

I understand that this information will be used for the purpose of:

☐ Providing information to allow care to be provided to the patient

☐ Supporting the payment of an insurance claim

☐ Other: _____

This authorization will be valid for the period of twelve months unless otherwise specified below.

I understand that I may revoke this consent at any time by sending a written notice. I understand that any release which has been made prior to my revocation which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the above named health care provider.

Signature of Patient or Patient's Authorized Representative _____

Relationship to Patient:_____ Date:_____

Specific authorization for release of information protected by state or federal law - I specifically authorize, by writing my initials beside the category and signing below, the release of data and information relating to:

☐ Substance abuse ☐ Mental Health ☐ AIDS/HIV

Signature of Patient _____ Date:_____

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Informed Consent for the Treatment of Sleep Disordered Breathing

You have been diagnosed by your physician as requiring treatment for sleep-disordered breathing (snoring and/or obstructive sleep apnea). This condition may pose serious health risks since it disrupts normal sleep patterns and can reduce normal blood oxygen levels, which in turn, may result in the following: excessive daytime sleepiness, irregular heartbeats, high blood pressure, heart attack, or stroke. All individuals are advised to consult with a physician for accurate diagnosis of their condition before treatment can be started.

What is Oral Appliance Therapy?

Oral appliance therapy for snoring/obstructive sleep apnea attempts to assist breathing during sleep by mechanically keeping the tongue and jaw in a forward position, thereby opening the airway space. Oral appliance therapy has effectively treated many patients. However, there are no guarantees that it will be effective for you, since everyone is different and there are many factors influencing the upper airway during sleep. It is important to recognize that even when the therapy is effective, there may be a period of time before the appliance functions maximally. During this time you may still experience the symptoms related to your sleep disordered breathing. **A postadjustment polysomnogram (sleep study) is necessary to objectively assure effective treatment. This must be obtained from your physician.** Oral appliance therapy does not cure snoring or obstructive sleep apnea. The device must be worn nightly for the duration of the disease, often for life.

Side Effects and Complications of Oral Appliance Therapy

Studies show that short-term side effects of oral appliance use may include excessive salivation, difficulty swallowing with appliance in place, sore jaws, sore teeth, jaw joint pain, dry mouth, gum pain, loosening of teeth and short-term bite changes (how the upper and lower teeth come together). There are also reports of dislodgement of ill-fitting dental restorations. Most of these side-effects are minor and resolve quickly on their own or with minor adjustment of the appliance. Long-term complications include bite changes that may be permanent, resulting from tooth movement or jaw joint repositioning. These complications may or may not be fully reversible once appliance therapy is discontinued. If not, restorative or orthodontic treatment may be required, for which you will be responsible.

Follow up visits with Dr. Diamond are mandatory to ensure proper fit and to allow an examination of your mouth to assure healthy condition. If unusual symptoms or discomfort occur that fall outside the scope of this consent, or if pain medication is required to control discomfort, it is recommended that you cease using the appliance until you are evaluated further.

Alternative Treatments for Sleep Disordered Breathing

Other accepted treatments for sleep-disordered breathing include behavioral modifications, positive airway pressure and various surgeries. It is your decision to have chosen oral appliance therapy to treat your sleep disordered breathing and you are aware that it may not be completely effective for you. It is your responsibility to report the occurrence of side effects and to address any questions to Dr. Diamond or the staff. Failure to treat sleep disordered breathing may increase the likelihood of significant medical complications.

If you understand the explanation of the proposed treatment, have asked Dr. Diamond or the staff any questions you may have about this form or treatment, please sign and date this form below. By your signature, you also acknowledge you have received a copy of this consent.

Signature of Patient _____ Date:_____